OBGYN WESTSIDE

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ DOB: _____

Previous Name: _____ Social Security #: _____

( ) I authorize OBGYN Westside to fax/scan and email (preferred method) a copy of my medical records

to:_____

( ) I authorize OBGYN Westside to request my medical records from:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax: _____

This request and authorization applies to:

- Healthcare information relating to following treatment, condition, or dates:

  _____

- Other: _____

Please login into your Mt. Sinai My Chart and check for results before requesting the results.

We require 10-14 business days to process your request. There is charge of ($0.75) per page. We charge expediting fees for urgent requests: $35 - 'within 24 hours' and $25 - 1-2 business days.

Signature: _____ Date:_____

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